MDS 3.0

Effective

October 1, 2013

Goals of the MDS 3.0

- Resident Voice – MDS 3.0 includes interviews for Cognitive Function, Mood, Personal Preferences, and Pain.

- Clinical Relevancy – MDS 3.0 Items are based upon clinically useful and validated assessment techniques.

- Efficiency – MDS 3.0 sections are formatted to facilitate usability and minimize staff burden.

Requirement for the 3.0

- The OBRA regulations require Nursing Homes that are Medicare certified, Medicaid Certified, or both, to conduct initial and periodic assessments for **all** their residents residing in the facility for 14 or more days.

- This includes hospice, respite, and special populations such as Pediatric and Psychiatric.

Responsibility of NF for Reproducing/Maintaining 3.0

- Federal regulatory requirements at 42CFR483.20(d) requires NH to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record

Responsibilities of NF for Reproducing/Maintaining 3.0

○ Nursing Homes may:

　1. Use electronic signatures for the MDS

　2. Maintain the MDS electronically

　3. Maintain the MDS and Care Plans in a separate binder in a location that is easily and readily accessible to staff, Surveyors, CMS etc.

Assessment Definitions
Assessment Reference Date (ARD)

- The ARD refers to the last day of the observation (or "look back") period that the assessment covers for the resident.
- Since a day begins at 12:00 AM and ends at 11:59 PM, the ARD must cover this period
- The facility is required to set the ARD within the appropriate timeframe of the assessment type being completed.
- **ARD should not be the same as the completion date**

Assessment Definitions
Observation Period

– **Observation (Look Back) period** The period of time over which the resident's condition or status is captured by the MDS Assessment

➤ **The "Look Back" period is 7 days unless otherwise stated on the MDS 3.0 Item Set**

- **If it did not occur during the look back period, it is not coded on the MDS.**

Assessment Definitions
Assessment Combination

- Assessment Combination refers to the use of one assessment to satisfy both OBRA and PPS assessment requirements when time frames required for both assessments coincide.

Assessment Definitions
Assessment Completion

- Assessment Completion refers to the date that all info needed has been collected and recorded for a particular assessment type, and staff have signed and dated that the assessment is complete.

Assessment Definitions Assessment Scheduling

- Assessment Scheduling refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and other observation periods required to complete the MDS items.

Assessment Definitions
Assessment Submission

○ Assessment Submission refers to electronic MDS data being in record and file formats that are capable of being transmitted to CMS

Assessment Definitions Transmission

○ Assessment Transmission refers to electronic transmission of submission files to the QIES Assessment Submission and Processing (ASAP) System using the Medicare Data Communication Network.

Assessment Definitions Transmission

- Transmission (submitted and accepted into MDS database) electronically no later than **14 days** after Completion;

- V0200C2, for comprehensive assessment

 - Z0500 for non-comprehensive assessment.

Assessment Definitions
MDS Assessment Codes

MDS Assessment Codes -refer to the values that correspond to the OBRA and PPS required assessments in items A0310A, A0310B, A0310C, and A0310F on the MDS 3.0.

Assessment Definitions
Medicare PPS Assessments

-5 day

-14 day

-30 day

-90 day

- Readmission/Return

-SCSA   -   SCPA

-Swing Bed Clinical Change

-Start of Therapy (SOT)   -   End of Therapy (EOT)

-Both Start and End of Therapy OMRA

-Change of Therapy (COT) OMRA

Item Sets

The various MDS 3.0 Assessments are called Item Sets.

There are 10 Nursing Home Item Sets.

1. Comprehensive Item Set (**NC**)
2. Quarterly Item Set (**NQ**)
3. PPS Item Set (**NP**)
4. OMRA-Start of Therapy Item Set (**NS**)

Item Sets

5. OMRA-Start of Therapy and Discharge Item Set (**NSD**)

6. OMRA Item Set (**NO**) Used for COT

7. OMRA Discharge Item Set (**NOD**)

8. Discharge Item Set (**ND**)

9. Tracking Item Set Entry/Death in Facility(**NT**)

10. Inactivation Request Item Set (**XX**)

Entry Tracking Record

○ An entry tracking record must be completed within 7days of the entry date

○ An entry tracking record must be transmitted within 14 days of the entry date.

Entry Tracking Record

- An entry tracking record must be completed every time a resident is

  - admitted for the first time

  - readmitted after discharge prior to completion of OBRA admission assessment

  - readmitted after discharge return not anticipated, or return anticipated but did not return within 30days

Comprehensive Assessments

○ Comprehensive MDS – Includes both the completion of the MDS and the CAAs and is done on:

1. Admission
2. Annually
3. Significant Change (SCSA)
4. Significant Correction to Prior Comprehensive Assessment (SCPA)

Comprehensive Assessments

- Refer to the handout from the RAI Manual – "RAI OBRA-required Assessment Summary Pg. 2-15 through 2-16" for timing requirements .

- Please review "Assessment Management Requirements/Tips for Comprehensive Assessments" in the 3.0 RAI User's Manual on Pg. 2-17 through 2-18.

Significant Change Criteria

○ MAJOR change

○ Not Self-limiting

○ 2 or more areas of decline/improvement (CMS 3.0 manual,   pgs. 2-20 through 2-27)

○ Requires IDT review and/or revision of Care Plan

A0310A Hospice Benefit

○ Electing or revoking the hospice benefit requires a significant change in status assessment

A0310. **Type of Assessment**

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** ass~~essment~~

A. Federal OBRA Reason for Assessment
01 **Admission** assessment (required by day 14)
02 **Quarterly** review assessment
03 **Annual** assessment
04 **Significant change in status** assessment
05 **Significant correction** to **prior comp**

Significant Error

Significant Error – is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and

2. The error has not been corrected via submission of a more recent assessment.

Non-Comprehensive Assessments

- **Non-Comprehensive MDS** –

  - does not require the completion of the CAAs

- **Non- Comprehensive MDS**   - Quarterly   - Significant Correction of Prior
          Quarterly (SCQA)

  - Discharge Assessment

        Return Anticipated

        Return Not Anticipated

- Refer to the handout from the RAI Manual – "RAI OBRA-required Assessment Summary Pg. 2-15 through 2-16" for timing requirements .

Non Comprehensive Assessments Discharge Assessment

Discharge- refers to the date a resident leaves the facility for anything other than a temporary LOA.

Discharge Assessment- refers to an assessment required upon resident discharge

-A discharge assessment is required for:

    1. Discharge return anticipated

    2. Discharge return not anticipated

Non Comprehensive Assessments Discharge Assessment

○ For Unexpected/Emergency Discharge:

- Complete all items possible on the assessment & code with "-" if unable to obtain the information

- CMS expects Staff Interviews to be done when the resident is discharged before he/she can be interviewed.

- CMS expects that there will be as few items as possible coded with "-"

Non Comprehensive Assessments Discharge

○ Per CMS: No longer have to submit a "Return NOT anticipated" when the resident was initially discharged as a "Return anticipated", but then they don't return. The computer program will automatically remove the resident from the list of recent assessments if no new assessments are submitted by day 30 from the date of discharge—"Return anticipated."

Entry and Discharge Reporting
Death in Facility Tracking Record

Death in Facility -refers to when a resident dies in the facility or dies while on a LOA.

-The facility must complete a Death in Facility tracking record.

-A discharge assessment is not required.

Assessment Definitions
Leave of Absence

Leave of Absence, or LOA, refers to:

- Temporary home visit
- Temporary therapeutic leave
- Hospital observation stay of less than 24h where resident is not admitted to hospital

Assessment Definitions
Leave of Absence

Leave of Absence or LOA, does not require completion of either discharge assessment or any entry tracking record.

Coding Section A
A0050- Type of Record

○ Code 1 if this is a new record that has not been previously submitted and accepted in the QIES ASAP system

○ Code 2 if this is a request to modify the MDS items for a record that has been submitted and accepted in the QIES ASAP system

○ Code 3 if this is a request to inactivate a record that already has been submitted and accepted in the QIES ASAP system

Coding Section A
A0310 Purpose

Identifies the information required to complete the type of assessment

May be completed for more than one reason

- All requirements for each type of assessment must be met

Determines what items set must be completed (see bottom of MDS 3.0 Form—NC, ND, NQ, etc.)

Coding Section A
A0310A Federal OBRA Reason for Assessment

01. Admission

02. Quarterly

03. Annual

04. Significant change in status

05. Significant correction to prior comprehensive

06. Significant correction to prior quarterly

99. Not OBRA required

Coding Section A
A0310B PPS Assessment

Includes scheduled and unscheduled assessments

Enter Code

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Sta
- 01. **5-day** scheduled assessment
- 02. **14-day** scheduled assessment
- 03. **30-day** scheduled assessment
- 04. **60-day** scheduled assessment
- 05. **90-day** scheduled assessment
- 06. **Readmission/return** assessment
PPS Unscheduled Assessments for
- 07. **Unscheduled assessment use**
Not PPS Assessment
- 99. **Not PPS** assessment

B. PPS Assessment
PPS Scheduled Assessments fo
- 01 **5-day** scheduled assessment
- 02 **14-day** scheduled assessment
- 03 **30-day** scheduled assessment
- 04 **60-day** scheduled assessment
- 05 **90-day** scheduled assessment
- 06 **Readmission/return** assessment
PPS Unscheduled Assessments for a
- 07 **Unscheduled assessment used**
Not PPS Assessment
- 99 **Not PPS** assessment

PPS Other Medicare Re

Coding Section A
A0310C PPS Other Medicare Required Assessment - OMRA

Indicates whether the assessment is related to therapy services

Complete this item for all assessments

- **Code 0.** Not an OMRA assessment
- **Code 1.** Start of Therapy when ARD is 5 - 7 days after first day of therapy services
- **Code 2.** End of Therapy when ARD is 1 - 3 days after
  last day of therapy services
- **Code 3.** Start and End of Therapy when ARD meets both therapy criteria
- **Code 4.** Change of Therapy Assessment

Coding Section A
A0310E First Assessment
Since Most Recent Admission

Indicate whether this is the first OBRA, PPS, or discharge assessment since the most recent admission

- Entry of any kind – admission or reentry

Complete this item for all assessments

Coding Section A
A0310F Entry/ Discharge Reporting

Indicate an entry or discharge reason for assessment or tracking record

Code 01 Entry Record – tracking form

Code 10 Discharge assessment – return not anticipated – requires clinical assessment

Code 11 Discharge assessment – return anticipated – requires clinical assessment

Code 12 Death in facility record – tracking form

Coding Section A
A0310G Type of Discharge

- Complete only if A0310F = 10 or 11
- Code 1 for a planned discharge
- Code 2 for an unplanned discharge

Coding Section A
A0410 Submission Requirement

Maine has both a State and Federal requirement

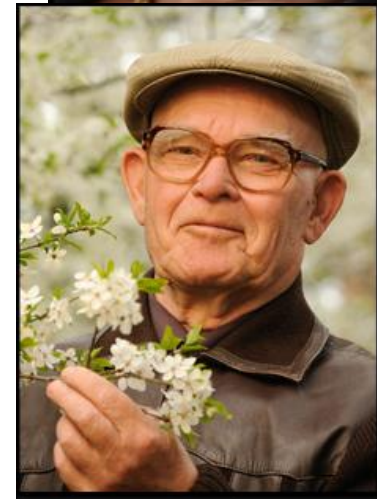**ALWAYS code 03 Federal required**

DO NOT TRANSMIT NON-OBRA MANAGED CARE OR MEDICARE ADVANTAGE ASSESSMENTS

Coding Section A
Resident Data

A0500 through A1300

- Personal data including Optional resident data listed in A1300.

Coding Section A
1500 PASRR/ Medicaid

All individuals admitted to Medicaid certified NFs must complete a Level I PASRR

If the Level I screen is positive, a Level II evaluation is performed

Individuals suspected to have serious mental illness and/or intellectual disability or related condition may not be admitted unless approved through a Level II PASRR determination

Coding Section A
A1510- Level II Preadmission Screening and Resident Review (PASRR) Conditions

- Complete only if at A0310A, Type of Assessment, you have coded 01 admission; 03 annual; 04 significant change; or 05 significant correction to prior comprehensive assessment
- Check all that apply

PASSAR

- http://www.qualitycareforme.com/ MaineProvider_PASRR.htm

MaineCare Case Mix

Maine uses the <u>RUG III Codes for Case Mix purposes</u>. This has been calculated for the MDS 3.0 based on the CMS Translator.

PPS uses RUG IV codes

- Maine will continue with the brain injury modification

Supporting Documentation for Case Mix payment items continues to be required

CASE MIX PAYMENT ITEMS

- Certain services, conditions, diagnoses and treatments that are on the MDS 3.0

MaineCare Case Mix (continued)

- Resident interviews **only** will be accepted as coded on the MDS 3.0—NO supporting documentation required.
- Staff interviews **must be documented** in the residents record. If the interviews are summarized in a narrative note, the interviewer must document the date of the interview, name of staff interviewed staff responses to questions asked.
- Follow all "Steps for Assessment" in the RAI Manual, for the interview items

FULL "ITEM SET" FORM
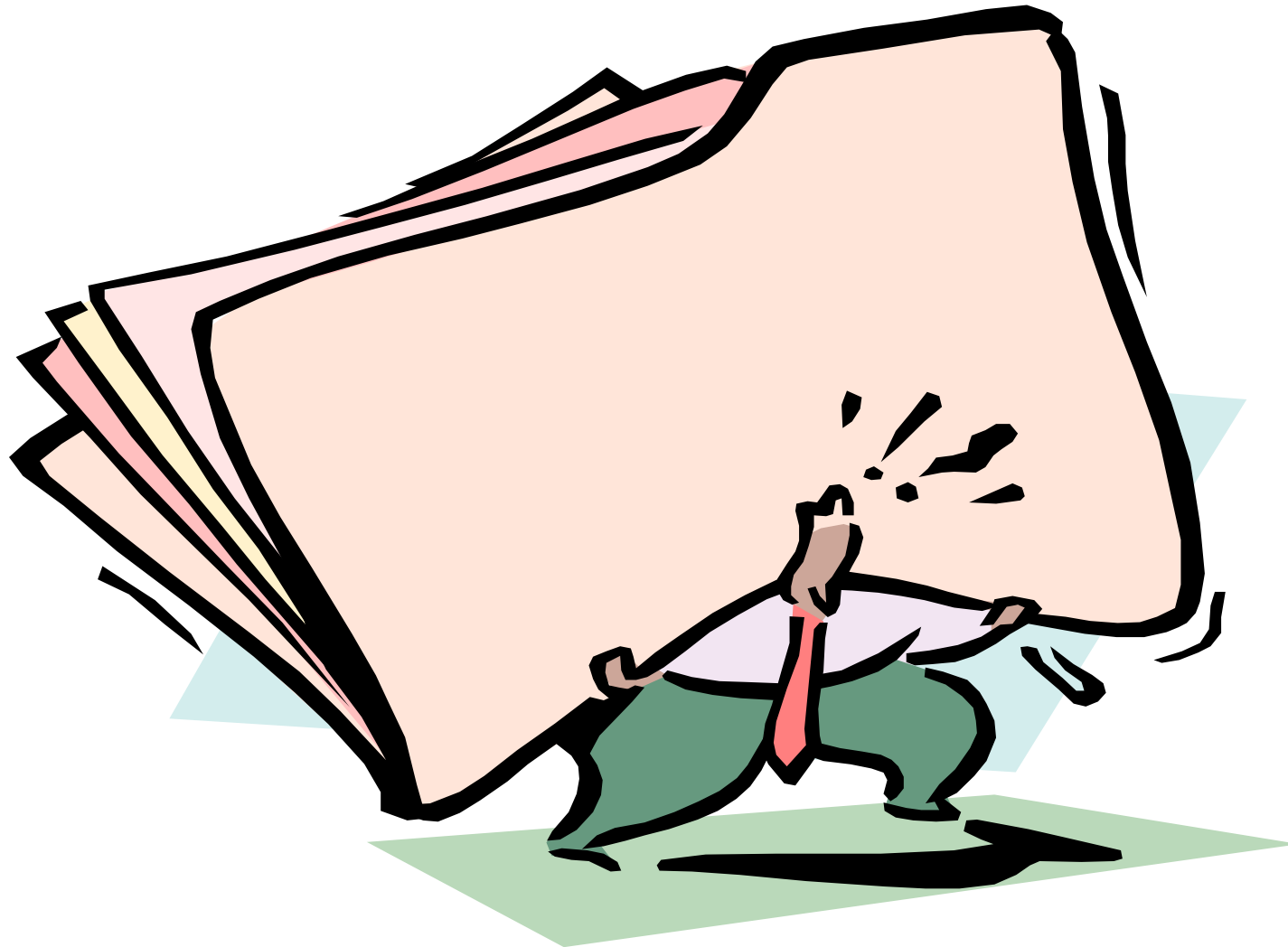
MDS 3.0
ITEM BY ITEM

Mostly Payment and New Items- Unless there are questions about other Sections

IMPAIRED COGNITION

Items

-B0100- Commatose

(requires supporting documentation)

-C0200

-C0300A,B,C

-C0400A,B,C

(Resident Interview- BIMS stands alone)

Or

-B0700

-C0700

-C1000

(Staff Assessment requires supporting documentation)

50

Depression Indicators

Resident Interview (PHQ-9)

- Items D02002A through D02002I
- Requires no further documentation

Depression Indicators

<u>Staff</u> Interview (PHQ-9-OV)

- Items D05002A through J

****Supporting Documentation Required****

BEHAVIORAL SYMPTOMS

Items

- E0100A Hallucinations
- E0100B Delusions
- E0200A Physical behaviors
- E0200B Verbal behaviors
- E0200C Other behaviors
- E0800   Rejected care
- E0900   Wandered

Section G
New on 3.0 for Self Performance

- Added a code of 7 for when the Activity occurred only once or twice
- Code Independent (0), only if "Independent" level of self-performance occurred EVERY TIME the activity occurred.
- Code 7 if activity occurred only once or twice
- Code 8 if activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Section G
ADL'S

Self-performance & Number of Support Persons:

G011A1,2 Bed mobility

G0110B1, 2 Transfer

G0110I, Toileting

Self-performance Only:

G0110H1 Eating

Section G
ADL's (continued)

○ Rule of Three (See ADL Algorithm Pg. G-7).

○ Exceptions:
- "0" Independent

- "4" Total dependence

- "7" Activity occurred one or two times
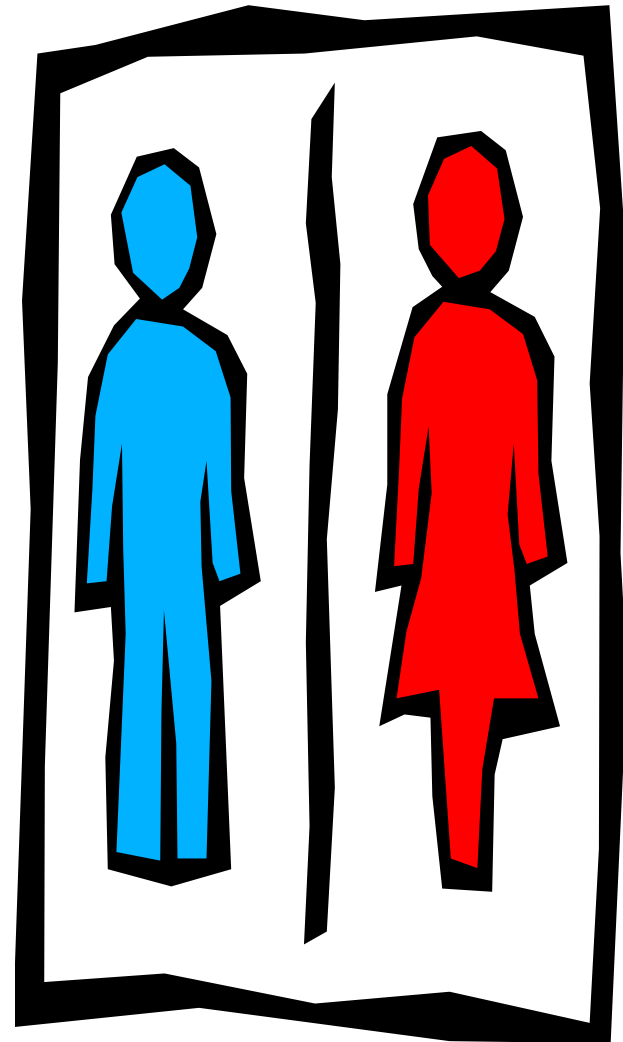
- "8" Activity did not occur

ADL SCORING

- See handout for RUG III ADL Score Chart for MDS3.0

Scheduled Toileting/Retraining

This is part of Restorative Nursing Programs so we will review Items H0200C & H0500 when we review Items O0500A - O0500J.

Section I Active Diagnoses

1. Identify diagnoses

   - Requires **documented** physician's diagnoses
   - Identify any diagnoses made in the last **60 days**

2. Determine diagnosis status

   - Using a **7-day** look-back period, determine if diagnosis is active or inactive
   - Active diagnoses have a direct relationship to the resident's functional or cognitive status, mood or behavior, medical treatments (including medication to manage the disease/condition), nursing monitoring, or risk of death during the look back period

59

DIAGNOSES (Case Mix Items)

I2900- Diabetes (N0300 must = 7 and O0700 must = 2 or more)

14300- Aphasia (must be with a feeding tube)

14400- Cerebral palsy

14900- Hemiplegia/hemiparesis

15100- Quadriplegia

15200- Multiple Sclerosis

15500- Traumatic brain injury (Maine only)

Infections

  I2000- Pneumonia

  I2100- Septicemia

I2300 Urinary Tract Infections

The look-back period for UTI (I2300) differs from other items

- **Look-back period to determine an _active diagnosis_ of a UTI is 30 days**

Code for a UTI **only if all** of the following criteria are met:

- Diagnosis of a UTI in last 30 days
- Signs and symptoms attributed to UTI
- Positive test, study, or procedure confirming a UTI
- Current medication or treatment for UTI

J1550 PROBLEM CONDITIONS

○ **J1550A(fever)—**must be at least 2.4F >baseline ("**should** be established prior to the ARD") (must be other condition as well—see Maine MDS RUG III Codes)

○ **J1550B(vomiting)—**episode must be W/I the 7 days (Must also be a fever)

○ **J1550C(dehydration)—**must be 2 or more clinical indicators (pg. J-26)

○ **J1550D(internal bleeding)—**must be clinical indicator W/I the 7 days.
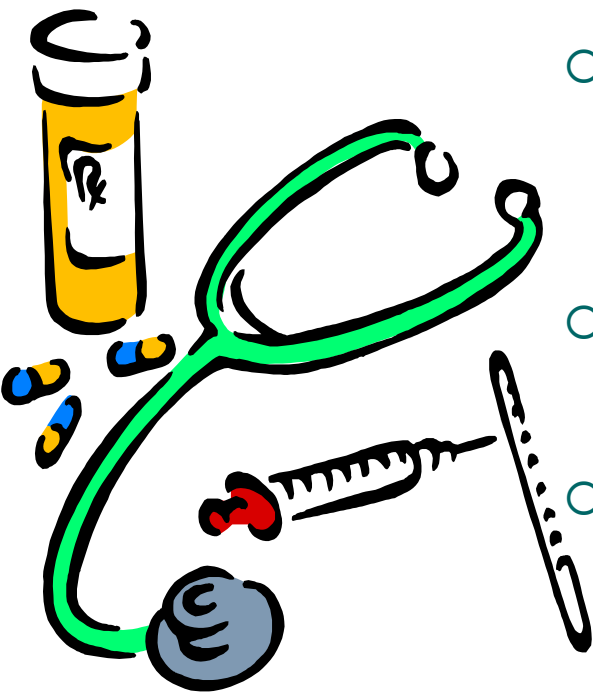
J1550 (Continued)

- A (Fever) The resident's baseline temperature **should be** established prior to the ARD.
- C (dehydration) Follow guidelines in Manual
- D (Internal bleeding) Guidelines:
  - May be frank or occult
  - Observe clinical indicators
  - **Do not code as internal bleeding:**
    - Nosebleeds that are easily controlled
    - Menses
    - Urinalysis that shows a **small** amount of red blood cells

Section K
Case Mix Payment Items

- **K0300** Weight Loss

- **K0510A** Parenteral/IV feeding

- **K0510B** Feeding tube

- **K0710A** TF/IV % calories

- **K0710B** TF/IV average fluid intake
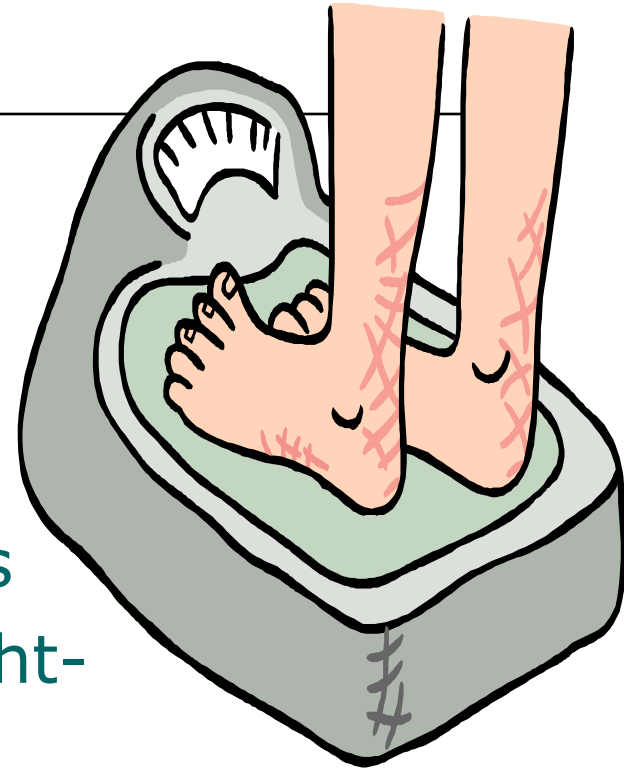
See Maine MDS RUG III Codes

K0300 - WEIGHT LOSS (Case Mix Item)

○ K0300 (must be in combination with fever (J1550A) for payment).

Codes have been expanded to indicate whether the resident is

on a physician-prescribed weight-loss regimen or not

○ Loss of 5% or more in the last month

○ Loss of 10% or more in the last six months

K0510 Nutritional Approaches

○ K0510 is split in to two columns

    1. While NOT a Resident

    2. While a Resident

    Timeframe is the last 7 days

K0510 Assessment Guidelines

Reminder: Code only items that were administered for nutrition or hydration

- "IV fluids can be coded in K0510 if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record."

K0510 Assessment Guidelines

○ The following items are **<u>NOT</u>** coded in K0510A:

- IV medications

- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay

- IV fluids administered solely as flushes

- Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis

RAI Manual pages K-10 through K-12

K0710 Percent Intake by Artificial Route

○ This item has three columns
- Column one = while not a resident
- Column two = while a resident
- Column three = during the entire 7 days

K0710 Percent Intake by Artificial Route

Complete K0710 only if column 1 and/or column 2 are checked for K0510A or K0510B

CALORIE/FLUID INTAKE

- **K0710A** (parenteral/enteral portion of total calories)

  - "Review intake records to determine actual intake. . ."
  - "If the resident had more substantial oral intake than just sips of fluid, consult with the dietician."

- **K0710B** (parenteral/enteral fluid intake average)

  - Review intake records from the last 7 days. Add up the total TF/IV fluid intake and divide by 7

71

Section M (Ulcers & Other Skin Problems) Case Mix Payment Items

- M0300A,B1, C1, D1, F1 & M1030 (Ulcers) with 2+ Treatments: M1200A, B, C, D, E, G, H

- M1040E (surgical site) or M1040D (open lesion) with M1200F, G or H

- M1040A, B, C (foot problems) with M1200I (foot dressing)

- M101F (burns—2nd or 3rd degree)
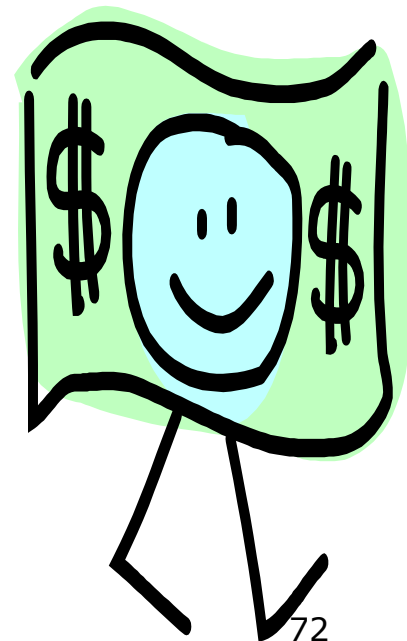
Section M: Skin Conditions

- Intent: to document the risk, presence, appearance and/or change of pressure ulcers and other skin ulcers, wounds or lesions and some treatments.

- CMS **adapted** (not <u>adopted</u>) the NPUAP 2007 definitions of Pressure Ulcer Stages, "therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this (RAI) Manual."

Pressure Ulcer: CMS Definition

"Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction."

PRESSURE ULCERS (Guidelines)

Do not reverse stage

○ "If the pressure ulcer has ever been classified at a **deeper stage** than what is observed now, <u>it should continue to be classified at the deeper stage</u>"

○ Determine the deepest anatomical stage of each pressure ulcer

○ Enter number of pressure ulcers for each stage

○ **Pressure Ulcers are Case Mix items**

- **2+ Treatments required**

Item M0300F Unstageable Related to Slough and/or Eschar

- "Although the wound bed cannot be visualized, and hence cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes."

- "The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur."

CMS Definitions

- Slough tissue: "Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough **may be adherent** to the base of the wound or present in clumps throughout the wound bed."

CMS Definitions

○ Eschar tissue: "Dead or devitalized tissue that is hard or soft in texture; usually black brown or tan in color, and may appear scab-like. Necrotic tissue and eschar are **usually firmly adherent** to the base of the wound and often the sides/edges of the wound"

M1030 Venous and Arterial Ulcers

- Definitions per CMS
  - Venous ulcers: "Ulcers cause by PVD, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg."
  - Arterial ulcers: "Ulcers caused by PAD, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus."

  - **This is a Case Mix item (2+ treatments)**

M1040 Other Ulcers Wounds and Skin Problems

○ **Foot problems** – check **all** that apply

- A. Infection of the foot ("cellulitis, purulent drainage")

- B. Diabetic foot ulcer ("ulcers caused by the neuropathic and small blood vessel complications of diabetes"). Documentation must support this.

- C. Other **open** lesion(s) on the foot (e.g. cuts, fissures)

M1040 Other Skin Problems (continued)

- ○ M1040D Open Lesion(s) other than ulcers, rashes, cuts (most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer).

- ○ Must be documentation of **"open"** in the 7 day look-back period.

M1040 Other Skin Problems (continued)

- M1040E Surgical wound(s)-- Do **not** include: Healed sites, healed stomas, lacerations with butterfly closures, PICC sites, Central line sites, peripheral IV sites or surgically debrided pressure ulcers (these should continue to be coded as pressure ulcers).

M1040 Other Skin Problems (continued)

- M1040F Burn(s) (Second or third degree): Skin and tissue injury caused by heat or chemicals and may be in ANY stage of healing.

- Do NOT include first degree burns (changes in skin color only).

- According to the Maine State Board of Nursing the degree of the burn must be diagnosed and documented by the physician

M1040 Other Skin Problems (continued)

○ To qualify for Case Mix RUG placement, there must be application of a specific treatment within the 7-day look-back period (see handout, Maine MDS RUG III Codes, Model Version 5.12 ME for MDS 3.0).

M1200 Skin and Ulcer Treatments

A & B-Pressure relieving devices **do not** include:

- Egg crate cushions of any type, donut or ring devices for chairs (The use of donut or ring devices violate current Standard of Practice)

C.   -Turning/repositioning program

- Specific approaches for changing resident's position and realigning the body
- Program should specify intervention and frequency
- Requires supporting documentation

D.   -Nutrition and hydration

- High calorie diets with added supplements to prevent skin breakdown
- High protein supplements for wound healing

SKIN & ULCER TREATMENTS (continued)

○ **M1200 (continued)**

- E. Ulcer care
- F. Surgical wound care
- G. Non-surgical dressing <u>other than to feet</u> (with/without topical meds)
- H. Ointment/meds <u>other than to feet</u>
- I.   Dressings to feet (with/without topical meds

-Must be a physician's order, Care Plan or Facility policy/protocol for each item coded

-Must be documentation of use in the 7 day-day look-back period.

-DO NOT code "G" or "H" for Pressure Ulcers (RAI Manual, pgs. M-35, 36)

INJECTIONS

- **Item N0300**
  - code number of **days** injections were received in the last 7 days or since admission/re-entry
  - Subcutaneous (for SC pumps, include only days that the SC injection site was started/restarted)
  - Intramuscular
  - Intradermal
  - Insulin is counted here <u>as well as at item N0350A (Insulin injections)</u>
 - DO NOT CODE I.V. access, meds or fluids here
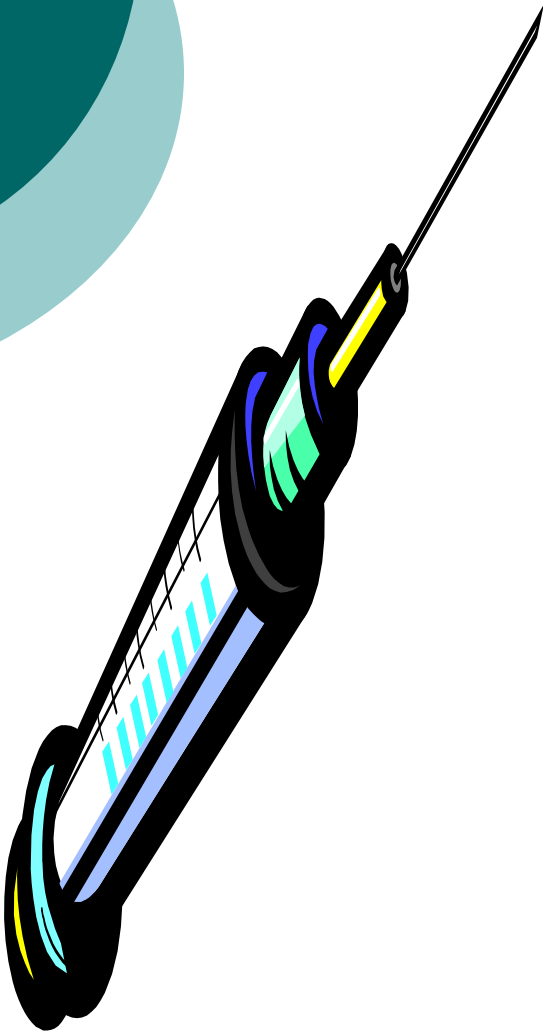
N0300- Injections

- This is a Case Mix Item when the number of days administered = 7 AND:
  - Physician documentation in the resident's record stating a diagnosis of diabetes (Item I2900)
  - Physician order change days = 2+ (Item O0700)

Treatments
Case Mix Payment Items

- **O0100A1,2** (Chemotherapy)—Must be used for documented diagnosis of cancer.
- **O0100B1,2** (Radiation)
- **O100C1,2** (Oxygen)
- **O0100D1,2** (Suctioning)—NOT oral.
- **O0100E1,2** (Trach. Care)—Ostomy and/or cannula
- **O0100F1,2** (Ventilator)
- **O0100H1,2** (IV/epidural meds)
- **O0100I1,2** (Transfusions)—NOT when administered during dialysis or chemo.
- **O0100J1,2** (Dialysis)
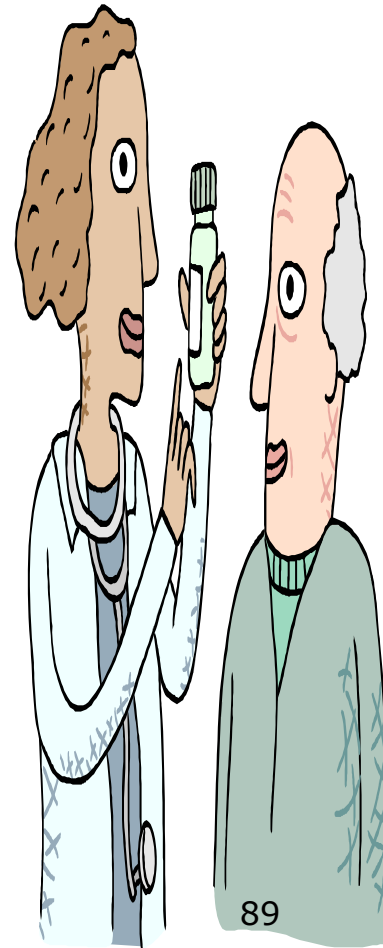
O0100 Special Treatment, Procedures, and Programs
Column 1 Coding Instructions

○ Document treatments received **before** becoming a resident of the facility

1. Check all treatments received by the resident:
   - **Prior** to admission/ reentry to the facility
   - **Within** the 14-day look-back period

2. Check **Z.** None of the above if resident:
   - Was admitted/ reentered during the look-back period AND
   - Did not receive any of the treatments listed

3. Leave Column 1 **blank** if resident was admitted or reentered facility more than 14 days ago

O0100 Special Treatments, Procedures, and Programs
Column 2 Coding Instructions

- Document treatments received **after** becoming a resident of the facility
- Check all treatments received by the resident:
  - **After** admission/reentry to the facility
  - **Within** the 14-day look-back period
- Check **Z.** None of the above if none of the treatments apply during the look-back period
- **Do not leave this column blank**

O0100 Special Treatments

- Items H and I: IV medication, and blood transfusions <u>administered during dialysis or chemotherapy</u> are considered part of the procedure and are **not coded under items O0100H (IV medications) and O0100I (transfusions). This also includes Item K0500A (Parenteral/ IV)**

O0400 Determine Applicable Therapies

○ Count only therapies that occurred since admission or reentry and <u>after</u> the <u>initial evaluation</u>

○ Do **NOT** include therapies that occurred while the resident was:

- An inpatient at a hospital or recuperative/ rehabilitation center or a different long-term care facility

- The recipient of home care or community-based services

O0400 Determine Applicable Therapies

- Speech/language, occupational, physical, respiratory, psychological and recreational therapy must meet the requirements for skilled therapy outlined in Chapter 3 <u>and</u> Appendix A of the RAI Manual

- Include services provided by a qualified physical/ occupational therapy assistant employed by the facility only if under the direction of a qualified therapist

- Do **<u>not</u>** include therapeutic services that are not specifically listed in the RAI Manual or on the MDS item set even if provided by specialists

Do not include non-skilled services

- Services provided at the request of the resident or family that are not medically necessary

- Maintenance treatments or supervision of aides performing maintenance services

- Services provided after a resident has been discharged from rehabilitation

Modes of Therapy

○ Three modes of therapy:

- Individual (one resident with one therapist or assistant's <u>full</u> attention)

- Concurrent

  ○ as defined for Medicare Part A

  ○ Medicare Part B has NO Concurrent therapy-Code 0

○ Group (as defined for Medicare Part A and Part B)

○ Documentation in the record must support MDS 3.0 coding for each mode of therapy

O0400 Therapies

- Respiratory therapy
  - Code MDS 3.0 for the <u>total</u> number of <u>minutes</u>
  - Code MDS 3.0 for the number of <u>days</u> therapy by a qualified professional was provided <u>for 15 minutes or more</u>
  - Does not include hand-held medication dispensers
- Recreational & psychological therapy
  - Not Case Mix payment items
  - Coding as above for respiratory therapy

Parameters for Coding Therapies

- Skilled therapy only by a "qualified professional" (see RAI Manual, Appendix A, pages A-14, 16, 17, 18, 19, 20)
- Therapies must be ordered by a physician/PCP "based on a qualified therapist's assessment (Case Mix will accept Care Planning in lieu of "therapist's assessment" for <u>respiratory therapy only).</u>
- Included on the Care Plan
- Periodic evaluation for effectiveness

O0400 Therapies Co-treatment

○ This is coded, "when two clinicians, each from a different discipline, treat one resident at the same time with different treatments." RAI Manual Chapter 3 pg. O-21.

○ Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.

O0420 Distinct Calendar Days of Therapy

- "If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding this item."

RESTORATIVE NURSING PROGRAMS

- O0500A, B, C, I (assistance)

- O0500D, E, F, G, H, J (training & skill practice)

- H0200C (scheduled urinary toileting program)

- H0500 (scheduled bowel toileting program)

Importance of O0500

- **Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible**
  - **Does not require a physician's order**
  - **A signature from an RN or LPN is required if therapy recommendations are being utilized**
- **This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning**

RESTORATIVE NURSING PROGRAMS

○ Restorative care **must meet** the following criteria:

- Measureable objective(s) and intervention(s) documented in the care plan and medical record

- Evidence of periodic evaluation by the licensed nurse must be present in the medical record

- Nursing assistants/aides must be trained in techniques that promote resident involvement in the activity

- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program
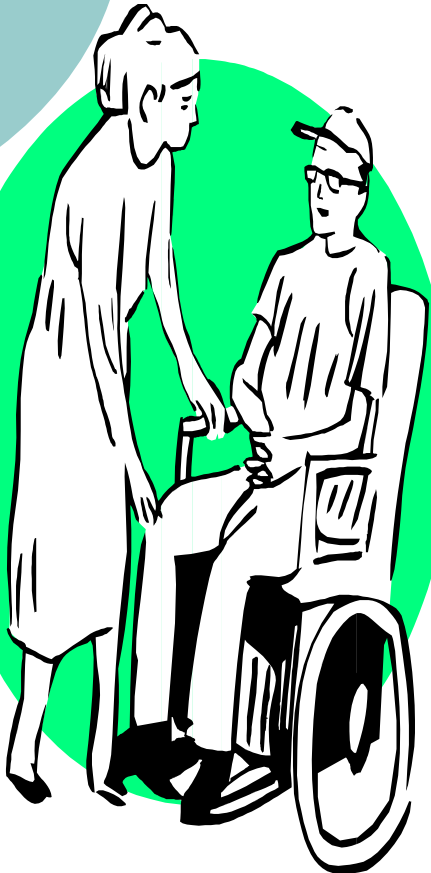
RESTORATIVE NURSING PROGRAMS

- Technique, training or skill practice must take place at least 15 minutes during the 24-hour period for O0500 A-J
  - Separate documentation is required for each restorative care item
  - Total the minutes of care provided across the 24-hour period
  - Cannot combine time across item categories
- Does **not** include groups with **more than four residents** per supervising helper or caregiver

H0200 Urinary Toileting Program

- H0200 **A through C captures three aspects of a resident's urinary toileting program:**

  - **H0200C = Current Toileting Program: Code this when an individualized, resident centered toileting program is being used to manage a resident's incontinence.**

  - **Documentation must support completion of the criteria identified in the care plan.**

- **See RAI manual pages H-1 through H-7**

H0200 Urinary Toileting Program

○ Urinary toileting program <u>does not</u> refer to:

- Simply tracking continence status
- Changing pads or wet garments
- Random assistance with toileting or hygiene

H0500 Bowel Toileting Program

- Bowel toileting program refers to the following three requirements:
  - Implementation of an individualized, resident-specific bowel toileting program.
  - Evidence that the program was communicated to staff and the resident through care plans, flow sheets and other documentation
  - Evidence that the program's effectiveness is periodically evaluated

- RAI manual reference pages H-11 through H-12

O0600 Physician Examination Days Assessment Guidelines

○ Examinations can occur in the facility or in the physician's office.

- May be a partial or full examination
- Documentation required

○ Do **not** include:

- Examinations that occurred prior to admission/ readmission to the facility
- Examinations that occurred during an ER visit or hospital observation stay
- Code only the number of days examinations were documented

O0700 Physician Order Change Days Assessment Guidelines

- Do **not** include the following:
  - Standard admission orders
  - Return admission orders
  - Renewal orders
  - Clarifying orders without changes
  - Orders prior to the date of admission/re-entry
  - Sliding scale dosage schedule
  - Notification that a PRN order was activated
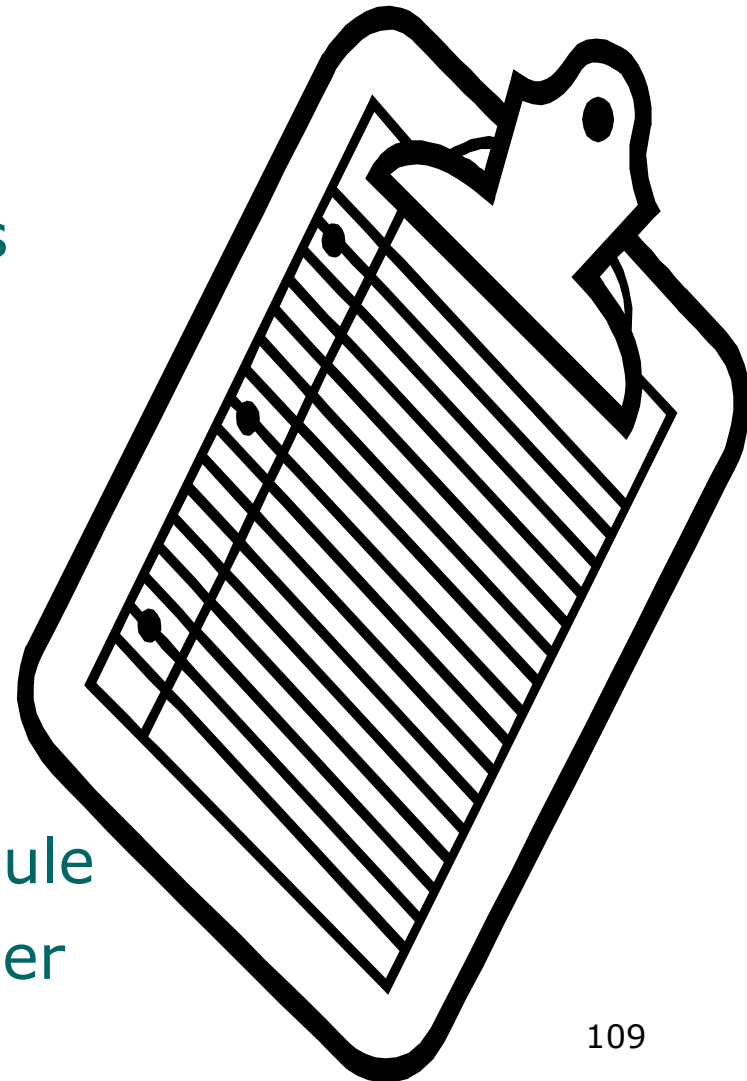
O0700- Physician Orders Assessment Guidelines

○ Do not include the following (continued):

- Monthly Medicare Certification

- Orders <u>only</u> written to increase the resident's RUG classification and facility payment

- Orders for transfer of care to another physician

- Orders written by a pharmacist

○ An order written on last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed

Section Q Participation in Assessment and Goal Setting

- Please read the directions carefully here.
- This is an important data collection section
- There are changes, skip patterns, etc
- FMI please call one of your State RAI Coordinator:
  - Kathy Tappan   287-9337
  - Suzanne Pinette   287-3933

Section Q Participation in Assessment and Goal Setting

○ Sections Q0500A and Q0500B have been added on the April 2012, 3.0

-Q0500A asks if the resident (or family or sig other or guardian, if resident unable to respond) want to be asked about returning to the community on **ALL** assessments.

-Code 0 = No (documentation is required)

-Code 1 = yes

-Code 9 = information not available

112

Section Q Participation in Assessment and Goal Setting

- Section Q0500B, Indicate information source for Q0500A
- Code 1 **Resident**
- Code 2 if not resident then **family or sig other**
- Code 3 if not resident, family or sig other, **then guardian or legally authorized representative**
- Code 8 **No information source available**

Section X
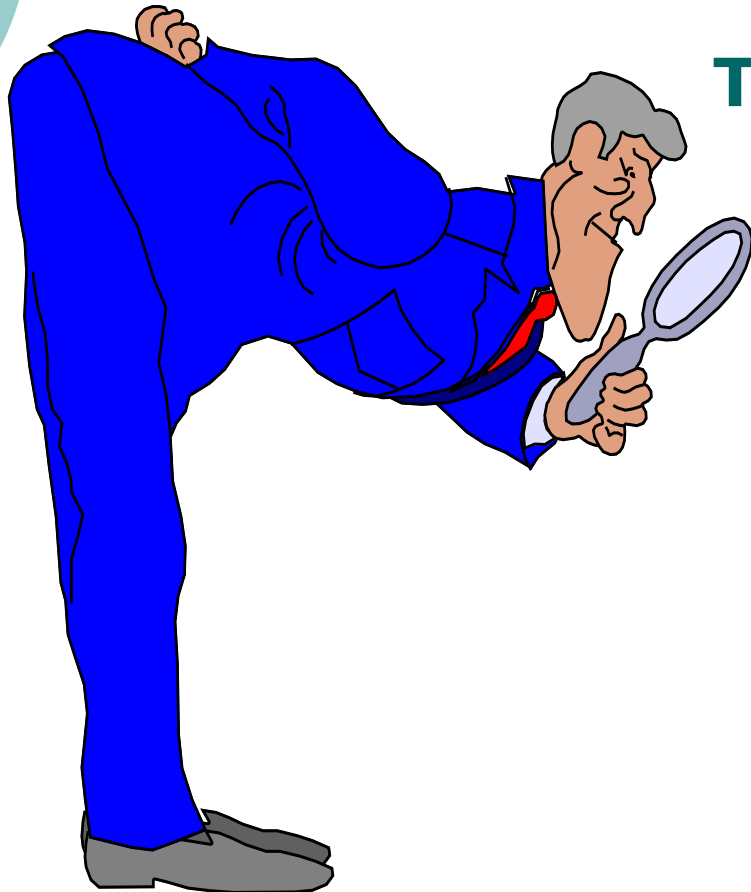
The purpose of Section X is to provide information necessary to modify or inactivate an MDS record.

Section X

A modification may be used for typographical errors in the following items:

- **A0310 - Type of Assessment**
- **A1600 – Entry Date**
- **A2000 – Discharge Date**
- **A2300 – Assessment Reference Date**
- **B0100 - V0200C – Clinical Items**

Section X (continued)

- AN INACTIVATION REQUEST IS STILL REQUIRED FOR ERRORS IN THE FOLLOWING ITEMS:
- - A0200- Type of provider
- - A0310- Type of Assessment where there is an Item Set Code change

Section S

This section applies to the State of Maine specific data requirements.

- <u>S0120 Residence Prior to Admission</u> – to document the resident's last community address.

- <u>S8010 Payment Source</u> – To determine payment source(s) that covers the daily perdiem or ancillary services for the resident's stay in the nursing facility over the last 30 days.
  - C3 – MaineCare perdiem. Do not check if MaineCare is pending
  - F3 – no longer in use
  - G3 MaineCare pays Medicare Co-pay

- <u>S8099 None of the above</u>